IDAHO DEPARTMENT OF
# HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

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February 19, 2010

Tom Whittemore
Communicare, Inc #6 Weiser
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #6 Weiser, provider #13G027

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #6 Weiser, which was conducted on February 11, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **March 4, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by March 4, 2010. If a request for informal dispute resolution is received after March 4, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Sylvia Cresswell for

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

Sylvia Cresswell

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G027 | A. BUILDING _____ B. WING _____ | 02/11/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COMMUNICARE, INC #6 WEISER | 180 EAST PARK ST WEISER, ID 83672 |

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| W 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the annual recertification survey.<br><br>The survey was conducted by:<br>Monica Williams, QMRP, Team Leader<br>Jim Troutfetter, QMRP<br>Trish O'Hara, RN<br><br>Common abbreviations/symbols used in this report are:<br>AQMRP - Assistant Qualified Mental Retardation Professional<br>IPP - Individual Program Plan<br>PT - Physical Therapist<br>QMRP - Qualified Mental Retardation Professional<br>TV - Television | W 000 | RECEIVED<br>MAR 12 2010<br>FACILITY STANDARDS | |
| W 112 | 483.410(c)(2) CLIENT RECORDS<br><br>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interviews, it was determined the facility failed to ensure all information was kept confidential for 15 of 15 individuals (Individuals #1 - #15) whose full names and diet orders were noted to be posed in the kitchen of the facility. This resulted in individuals' information being available to other individuals, visitors, and non-staff. The findings include:<br><br>During an environmental review on 2/10/10 from 12:15 - 12:55 p.m., it was noted a menu, dated 2005, was posted on the refrigerator. The menu | W 112 | W112<br><br>Corrective Actions & System Changes: We are aware of and support this expectation and have information in our Policy and Procedure Manual addressing confidentiality. However, in reviewing this policy the issue of posting identifying information was not specifically addressed in the policy. We have therefore adjusted this policy and will send out policy clarification to all CCI locations with the expectation that QMRPs will review this information at the next scheduled staff meeting at each location.<br><br>Identifying Others Potentially Affected: System Changes: All individuals at this location were affected. | 3-10-10 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Tom Whittemore | Administrator | 3-10-2010 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W 112 | Continued From page 1<br>identified Individuals #1 - #15 by their first and last names along with their diet orders. When asked, a present staff stated they had not noticed it before and proceeded to remove the menu from the refrigerator.<br><br>When asked, the QMRP stated during an interview on 2/11/10 from 9:10 - 11:00 a.m., individuals' full names and diet orders were not to be posted on the refrigerator.<br><br>The facility failed to ensure information was kept confidential for Individuals #1 - #15. | W 112 | Monitoring: As part of the monthly maintenance checklist, Assistant QMRPs (House Managers) will now be expected to review all postings at assigned locations. This report is sent to the Administrator for review. | |
| W 154 | 483.420(d)(3) STAFF TREATMENT OF CLIENTS<br><br>The facility must have evidence that all alleged violations are thoroughly investigated.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of incident reports and staff interviews, it was determined the facility failed to ensure all injuries of unknown origin were thoroughly investigated for 4 of 15 individuals (Individuals #3, #5, #11, and #12) for whom injuries of unknown origin were reported. This resulted in an absence of appropriate investigations. The findings include:<br><br>1. Incident reports, dated 4/09 - 2/5/10, were reviewed and showed the following injuries of unknown origin were not thoroughly investigated, as follows:<br><br>a. For Individual #5:<br><br>- On 6/10/09 at 11:00 a.m., Individual #5 was found with a bruise on his forehead. The report | W 154 | W154<br><br>We are concerned about any injury which occurs including minor injuries of the nature included in this citation. The people included in the citation are older, physically active and not provided at present with one to one supervision, therefore determining the exact cause of infrequent injuries is often difficult.<br><br>Corrective Actions & System Changes: Updated instructions on how to conduct an "Injury of Unknown Origin Investigation" (see attached) and will inservice all Assistant QMRPs (House Managers) on this update.<br><br>Identifying Others Potentially Affected: System Changes: All individuals at this location were affected.<br><br>Monitoring: The RN Supervisor is now reviewing all Accident/Injury Reports | 3-10-10 |

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| W 154 | Continued From page 2<br>showed 1 staff was interviewed who thought it could have been from bending down to pick up something and bumping his head. The report did not contain evidence of additional staff interviews to rule out the actual cause of the injury.<br><br>- On 6/25/09 at 7:40 p.m., Individual #5 was found with a scratch on his left knee. The report showed 1 staff was interviewed who thought it could have been from self injurious behavior or bumping into something. The report did not contain evidence of additional staff interviews to rule out the actual cause of the injury.<br><br>- On 7/19/09 at 6:00 p.m., Individual #5 was found with an abrasion on the back of his right thigh. The report showed 1 staff was interviewed who thought it could have been from the way he exited the van. The report did not contain evidence of additional staff interviews to rule out the actual cause of the injury.<br><br>- On 12/25/09 at 7:25 a.m., Individual #5 was found with bruising to his upper left eyebrow and eyelid and an abrasion on his left cheek. The report showed 2 staff were interviewed who thought it could have been from bumping into something. The report did not contain evidence of additional staff interviews to rule out the actual cause of the injury.<br><br>b. For Individual #12:<br><br>- On 4/28/09 at 9:30 a.m., Individual #12 was found with 2 bruises under his left nipple. The report showed the 2 staff were interviewed who thought it was possibly caused from maladaptive behavior the previous day. The report did not contain evidence of additional staff interviews to | W 154 | on a monthly basis, will add a review of these investigations to her review, and will report problematic findings to the AQMRP, QMRP, and Administrator. | |

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| W 154 | Continued From page 3 | W 154 | | |

rule out the actual cause of the injury.

- On 6/18/09 (no time indicated), Individual #12 was found with a bruise on his left breast. The report did not contain evidence of an investigation.

- On 10/27/09 at 2:10 p.m., Individual #12 was found with a bruise on his forehead. The report showed the 2 staff who found the injury, thought he possibly bumped his head on something. The report did not contain evidence of additional staff interviews to rule out the actual cause of the injury.

- On 12/28/09 at 3:00 p.m., Individual #12's right eye was noted to be blackened. The report showed 1 staff was interviewed who thought it could have been opening his door and bumping into it. The report did not contain evidence of additional staff interviews to rule out the actual cause of the injury.

d. For Individual #11:

- On 7/12/09 at 4:15 (a.m. or p.m. was not indicated), Individual #11 was found with a bruise on the front of his left thigh. The report showed 1 staff person was interviewed who stated he had a maladaptive behavior prior to finding the bruise. The report did not contain evidence of additional staff interviews to rule out the actual cause of the injury.

- On 11/22/09 at 10:20 a.m., Individual #11 was found with a bruise on the left side of his back. The report showed 1 staff person was interviewed who thought it could have been from a restraint that occurred on 11/20/09. The report did not

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| W 154 | Continued From page 4<br>contain evidence of additional staff interviews to rule out the actual cause of the injury.<br><br>- On 12/6/09 at 9:00 a.m., Individual #11 was found with a bruise under his eye. The report did not contain evidence of an investigation.<br><br>e. For Individual #3:<br><br>- On 7/15/09 at 3:55 p.m., Individual #3 was found with a quarter-size bruise on the outside of her left leg. The report did not contain evidence of an investigation.<br><br>- On 7/28/09 at 7:45 p.m., Individual #3 was found with blisters on her left arm. The report stated it was possibly from her watchband or she could have bumped into something. The report did not contain evidence of staff interviews to rule out the actual cause of the injury.<br><br>When asked, the Home Supervisor stated during an interview on 2/11/10 from 9:10 - 11:00 a.m., the incidents noted above were not thoroughly investigated and it would be better to have more information.<br><br>The facility failed to ensure all injuries of unknown origin were thoroughly investigated. | W 154 | | |
| W 218 | 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN<br><br>The comprehensive functional assessment must include sensorimotor development.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review, and staff interviews it was determined the facility failed to ensure an individual's physical therapy | W 218 | W218<br><br>Corrective Actions & System Changes: The Physical Therapist has again re-evaluated this individual and recommendations are being implemented.<br><br>Identifying Others Potentially Affected: System Changes: All individuals at | 3-10-10 |

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| W 218 | Continued From page 5<br>assessment was updated as needed for 1 of 4 individuals (Individual #3) whose physical therapy assessment was reviewed. This resulted in an individual's assessment not being an accurate reflection of her current mobility status. The findings include:<br><br>Individual #3's IPP, dated 8/20/09, documented an 83 year old female diagnosed with severe mental retardation and bipolar disorder. Her IPP included a service objective which stated she was to use her walker to ambulate.<br><br>Individual #3's Active Treatment Schedule, dated 4/1/09, documented Individual #3 was to be assisted to "walk with her walker to a chair in the tv [sic] room."<br><br>Additionally, Individual #3's Ancillary Log, dated 7/14/09, contained a note from the PT which stated "She still needs to walk regularly for exercise."<br><br>During 4 observations conducted in the facility on 2/8/10 and 2/9/10 for a cumulative 6 hours and 37 minutes, Individual #3 was not noted to use her walker.<br><br>When asked about the walker during an interview on 2/11/10 from 9:10 - 11:00 a.m., the AQMRP stated Individual #3 did not use her walker because it was unsafe. The AQMRP provided the survey team with Individual #3's Trainer Feedback forms, dated 9/1/09 - 2/5/10, which documented Individual #3 had difficulty standing and maintaining her balance, she was increasingly unsteady, and was too unsteady to perform any of her exercises. When asked if Individual #3 had an updated Physical Therapy | W 218 | this location are affected although no other observations of this nature were reported by the survey team.<br><br>Monitoring: We feel this was an oversight and is not a systematic problem as many of the individuals served at this location have issues of aging and no other similar observations of not addressing these types of needs were observed. We will ask the Physical Therapist to do an inservice related to the aging process and when to contact him about issues. | |

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| W 218 | Continued From page 6<br>Evaluation to address her decreased ability to walk, the AQMRP stated no.<br><br>The facility failed to ensure Individual #3's Physical Therapy Evaluation was updated when her physical status changed. | W 218 | | |
| W 312 | 483.450(e)(2) DRUG USAGE<br><br>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individual's IPP that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified the drug usage and how it may change in relation to progress or regression. The findings include:<br><br>Individual #1's IPP, dated 8/20/09, documented an 83 year old female diagnosed with profound mental retardation, bipolar disorder, and dementia.<br><br>Her medical record showed she received Valium (an anti-anxiety drug) 15 mg on 5/4/09 for a visual examination. However, her record did not contain | W 312 | W312<br>Corrective Actions & System Changes: The lack of inclusion of this medication was an oversight as the QMRP did obtain consent. This will be corrected as we have a system in place for processing this information.<br><br>Identifying Others Potentially Affected: System Changes: All individuals at this location are potentially affected and all orders for these types of PRN medications will be reviewed and added if not already included.<br><br>Monitoring: The QMRP Supervisor prepared this information so the initial oversight was her responsibility. The QMRP did not catch the oversight when reviewing and filing the document. The Quality Assurance Process which would have caught this oversight was scheduled to occur in February. Each will redo their part of the process and until corrections are insured. | 4-1-10 |

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| W 312 | Continued From page 7<br>a plan for the use of the drug.<br><br>When asked, the QMRP stated during an interview on 2/11/10 from 9:10 - 11:00 a.m., it was overlooked and there was no plan.<br><br>The facility failed to ensure a plan related to the use of Valium was developed for Individual #1. | W 312 | | |
| W 436 | 483.470(g)(2) SPACE AND EQUIPMENT<br><br>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review, and staff interview it was determined the facility failed to ensure an individual's adaptive equipment was kept in good repair for 1 of 3 individuals (Individual #1) reviewed, who required adaptive equipment for mobility. This resulted in an individual's wheelchair being in disrepair. The findings include:<br><br>Individual #1's IPP, dated 8/20/09, documented an 83 year old female diagnosed with profound mental retardation, bipolar disorder, and dementia.<br><br>Individual #1's Occupational Therapy Report, dated 7/16/08, included a recommendation to stabilize the footrests on Individual #1's wheelchair in order for her to feel grounded. | W 436 | W436<br><br>Corrective Actions & System Changes/Wheel Chairs: Many individuals at this location use wheelchairs for mobility. We have implemented a wheelchair and adaptive equipment check and response system but are having both internal and external issues with this system. To ensure internal implementation, check of this system has been added to the monthly preventative maintenance checklist and the QMRP is now assigned to review this system. We have less control over external systems. The only wheelchair maintenance service now requires preauthorization before they will do any repair and this is a time consuming process. In addition, repairs and ordering of parts often takes long periods of time. The Administrator and/or RN Supervisor will continue to work with this provider in an attempt to resolve these issues and the AQMRP have been instructed to document all these issues. We will adjust our service objective to "Repair adaptive equipment" "as needed". | 4-1-10 |

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| W 436 | Continued From page 8<br>An observation was conducted in the facility on 2/8/10 from 5:25 - 7:05 p.m. During that time, it was noted there was no left footrest on Individual #1's wheelchair. Additionally, she was noted to be transferred from the living room recliner to her wheelchair. Prior to the transfer, staff were noted to lock the brakes on the wheelchair. However, during the transfer, the wheelchair was noted to move backward. When asked, present staff stated Individual #1's wheelchair had been in disrepair for at least 8 months.<br><br>Further, during an observation on 2/9/10 from 10:18 - 11:25 a.m., Individual #1 was noted to have two different footrests such that one foot was higher than the other.<br><br>When asked, the QMRP stated during an interview on 2/11/10 from 9:10 - 11:00 a.m., he was not aware of the brakes or mismatched footrests on Individual #1's wheelchair.<br><br>The facility failed to ensure Individual #1's wheelchair was kept in good repair. | W 436 | Identifying Others Potentially Affected: System Changes: Individuals using wheelchairs at this location are potentially affected.<br><br>Monitoring: As part of the monthly maintenance checklist, Assistant QMRPs (House Managers) will review adaptive equipment needs. This report is sent to the Administrator for review. In addition, the QMRP will review the Wheelchair Maintenance and Response System. | |
| W 448 | 483.470(i)(2)(iv) EVACUATION DRILLS<br><br>The facility must investigate all problems with evacuation drills, including accidents.<br><br>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure all problems with evacuation drills were investigated for 15 of 15 individuals (Individuals #1 - #15) residing in the facility. This resulted in the potential for problems to continue. The findings include: | W 448 | W448<br><br>Corrective Actions & System Changes: We have developed the attached investigative process related to problematic fire drills and will reinservice QMRPs on this process.<br><br>Identifying Others Potentially Affected: System Changes: All individuals at this location were affected.<br><br>Monitoring/Frequency: The House Supervisor will review fire drills after they occur and report problematic | 4-1-10 |

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| W 448 | Continued From page 9<br>1. The facility's evacuation drills, dated 2/15/09 - 1/24/10, showed a total of 8 drills occurred on the graveyard shift during that time. The drills showed it took anywhere from 8 minutes to 18 minutes to evacuate and only 2 of the 8 drills were investigated, as follows:<br><br>For Side 160:<br>3/30/09 at 11:50 p.m. - 13 minutes to evacuate. No problems were noted.<br>6/27/09 at 2:13 a.m. - 16 minutes to evacuate.<br>7/24/09 at 5:30 a.m. - 10 minutes to evacuate. The drill was investigated and showed Individual #9 refused to evacuate.<br>10/12/09 at 6:00 a.m. - 8 minutes to evacuate. No problems were noted.<br><br>For Side #180:<br>3/30/09 at 11:12 p.m. - 13 minutes to evacuate. No problems were noted.<br>6/27/09 at 1:50 a.m. - 12 minutes to evacuate. The drill was investigated and showed Individual #11 refused to evacuate.<br>7/24/09 at 4:45 a.m. - 18 minutes to evacuate. No problems were noted.<br>10/12/09 at 6:00 a.m. - 8 minutes to evacuate. No problems were noted.<br><br>When asked, the QMRP stated during an interview on 2/11/10 from 9:10 - 11:00 a.m., the facility was recently informed that evacuations lasting over 8 minutes was excessive and was not an acceptable practice. The QMRP stated the remaining 6 drills with excessive evacuation times were not investigated.<br><br>The facility did not ensure all problems with evacuation drills were investigated. | W 448 | findings to the QMRP. Investigations will be reviewed by the Administrator as they are submitted and any problematic reports will be discussed with administrative staff at scheduled meetings. | |

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G027 | A. BUILDING _____ B. WING _____ | 02/11/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNICARE, INC #6 WEISER | 180 EAST PARK ST WEISER, ID 83672 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| MM177 | 16.03.11.075.09 Protection from Abuse and Restraint<br><br>Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10).<br>This Rule is not met as evidenced by:<br>Refer to W154. | MM177 | MM177<br><br>Please refer to W154<br><br>RECEIVED<br>MAR 12 2010<br>FACILITY STANDARDS | |
| MM197 | 16.03.11.075.10(d) Written Plans<br><br>Is described in written plans that are kept on file in the facility; and<br><br>This Rule is not met as evidenced by:<br>Refer to W312. | MM197 | MM197<br><br>Please refer to W313 | |
| MM199 | 16.03.11.075.11 Assurance of Confidentiality<br><br>Assurance of Confidentiality. Each resident admitted to the facility must be assured confidential treatment of his personal and medical records, and must be permitted to approve or refuse their release to any individual outside the facility except:<br>This Rule is not met as evidenced by:<br>Refer to W112. | MM199 | MM199<br><br>Please refer to W112 | |
| MM336 | 16.03.11.110.04(b) Emergency Plans<br><br>Emergency plans must be thoroughly tested and used as necessary to assure rapid and efficient | MM336 | MM336<br><br>Please refer to W448 | |

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3-10-10

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G027 | A. BUILDING _____ B. WING _____ | 02/11/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| MM336 | Continued From page 1<br>function.<br>This Rule is not met as evidenced by:<br>Refer to W448. | MM336 | | |
| MM429 | 16.03.11.120.11 Equipment and Supplies for Resident Care<br><br>Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents.<br>This Rule is not met as evidenced by:<br>Refer to W436. | MM429 | MM429<br><br>Please refer to W436 | |
| MM724 | 16.03.11.270.01(a) Assesments<br><br>As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case.<br>This Rule is not met as evidenced by:<br>Refer to W218. | MM724 | MM724<br><br>Please refer to W218 | |

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0036
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February 17, 2010

Tom Whittemore
Communicare #6 Weiser
40 West Franklin Road, Suite F
Meridian, ID 83642

Provider #13G027

Dear Mr. Whittemore:

On **February 11, 2010**, a complaint survey was conducted at Communicare #6 Weiser. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00004466**

Allegation: Non-licensed staff are administering individuals' medications without their participation.

Findings: An unannounced onsite complaint investigation was conducted from 2/8/10 to 2/11/10. During that time, observations and interviews were conducted with the following results:

Eight individuals were observed receiving medications on 2/8/10 and 2/9/10 across two different shifts. Both oral and injectable medications were given. All individuals were noted to participate in the administration of their medications including one individual who set his own insulin pen and independently injected himself.

Staff were interviewed during medication administration on 2/8/10 and 2/9/10 and were able to state individuals' level of participation as part of the medication process.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/mlw